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In the Supreme Court
OF THE
United States

OCTOBER TERM, 1984

MARIO DE MODENA dba
SIXTH AVENUE PHARMACY, et al.,
Petitioners,
v.
KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,
v.
KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Is the Nonprofit Institutions Act exemption to the Robinson-Patman Act applicable to the purchase of pharmaceuticals by the Kaiser Permanente Medical Care Program for the purpose of fulfilling its health care obligations to its members?

LIST OF PARTIES

Parties to the proceeding in the United States Court of Appeals for the Ninth Circuit were as follows:

Portland Retail Druggists Association, Inc.; Mario DeModena dba Sixth Avenue Pharmacy; Hillcrest North Pharmacy; De Anza View Enterprises; The Apothecary Shop; Edwin Drucker dba Mission Park Pharmacy; Roger W. Born dba MacLay Drug Company; Wellington, Inc; Jewell Pharmacy, Inc.; Eugene Elkin dba Kustner's Medical Square Pharmacy; WVP Corporation; unidentified owners and operators of retail pharmacies in Oregon, Washington and California.

Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Colorado; Kaiser Foundation Health Plan of Ohio (formerly Kaiser Community Health Foundation); Kaiser Foundation Health Plan of the Northwest (formerly Kaiser Foundation Health Plan of Oregon); Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (formerly Kaiser-Georgetown Community Health Plan, Inc.); Kaiser Foundation Health Plan of Connecticut, Inc.; Kaiser Foundation Health Plan of Texas; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Northwest Permanente/P.C.; Hawaii Permanente Medical Group, Inc.; Ohio Permanente Medical Group, Inc.; Colorado Permanente Medical Group, P.C.; Capital Area Permanente Medical Group, P.C.; Permanente Medical Association of Texas.

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SUMMARY OF ARGUMENT

The rule for deciding this case was announced by this Court in *Abbott Laboratories v. Portland Retail Druggists Association*, 425 U.S. 1 (1976), and properly applied by the Court of Appeals in this case. In *Abbott Laboratories*, this Court held that the Nonprofit Institutions Act ("NIA") extends to purchases that further the exempt purchaser's institutional function.

The Kaiser Permanente Medical Care Program ("Program") is a prepaid health care delivery system. Its institutional function is to deliver comprehensive health care to its members, who must utilize Program facilities and health care providers to obtain covered care and services, including prescription drugs. Over 99 percent of the drugs dispensed through Program pharmacies are to Program members, and the Program does not compete in the retail drug market where plaintiffs compete.

Starting as an industrial health plan, the Program first accepted community enrollment in 1945. Today, 40 years later, the Program and other plans on the Program model serve less than four percent of the U.S. population. Program pharmacies are not going to displace community pharmacies.

This is a case for applying the principles enunciated in *Abbott Laboratories*, which the Court of Appeals properly did. The case presents no new question calling for Supreme Court guidance.

STATEMENT OF THE CASE

Kaiser Foundation Health Plan, Inc., and its subsidiary, Kaiser Foundation Health Plan of the Northwest ("Health Plans"), are qualified nonprofit HMOs under the Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e *et seq.*, ("HMO Act"), and are exempt from federal income tax as charitable organizations under Internal Revenue Code § 501(c)(3). The Health Plans, together with Kaiser Foundation Hospitals ("Hospitals") and independent Groups of contracting physicians ("Medical Groups"), constitute the Program.

Under its membership contracts with groups and individuals, each Health Plan assumes responsibility to deliver comprehensive, predominantly prepaid health care

services to its members.[1] Covered health care services include unlimited hospitalization, complete services of physicians in the hospital and in the doctor's office, complete laboratory and x-ray services, prescribed eyeglasses and prescribed drugs, mental health care, medical social services, health education classes, and services of numerous ancillary health professionals. Prescription drugs are an important but comparatively minor element in the total spectrum of health care services provided through the Program.

All Program pharmacies are operated as professional prescription pharmacies, and not as general merchandise outlets. Prescription drugs represent more than 95% of the value of items dispensed, and the only other items dispensed are nonprescription drugs and health care supplies. Most pharmacies are accessible only from an interior hall of the hospital or outpatient medical office facility in which they are located. Only a few pharmacies have direct access to public streets. The pharmacies are not identified by outdoor signs, and the interior signs that identify pharmacy locations are of the same size and style as other directional and informational signs in the Program facility where the pharmacy is located. The Program does not seek non-member drug sales. No promotional, advertising or merchandising activities are conducted by or on behalf of any Program pharmacy.

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[1] Kaiser Foundation Health Plan, Inc. and its eight subsidiary plans operate in 10 geographic areas, called regions. Each Health Plan satisfies its responsibility to provide care principally through two Service Agreements. Under a Medical Service Agreement, the regional Medical Group provides professional and related services. Under a parallel Hospital Service Agreement, Kaiser Foundation Hospitals, a nonprofit and tax-exempt charitable organization, provides hospital and related services.

Health Plans and Hospitals are under common control. Each of the 10 regional Medical Groups is independent of Health Plan, Hospitals, and all other Medical Groups.

A person cannot become just a Program "drug member", but must enroll for comprehensive health care services. The District Court found the Program's negligible non-member sales (less than one percent of the total) to be *de minimis*, but the Court of Appeals remanded for "an evaluation of the impact of [non-member] sales on competition in the retail drug market."

The Health Plans compete not for community drug sales, but at a different functional level and in another market. That market is prepaid health care, and the Program's principal competitors are Blue Cross/Blue Shield, and health insurers such as Metropolitan and Prudential.

The Program first opened to the community in 1945. From its inception until the HMO Act, the Program was called a "group practice prepayment plan". Although group practice prepayment plans are a type of HMO, "HMO" is an umbrella term that covers a number of other, dissimilar arrangements.[2] Principal among these is the individual practice association ("IPA"). "The IPA, often sponsored by local, county, or state medical societies, contracts with providers to deliver services to [IPA] patients from the provider's own office." S. Schmidt, "Health Maintenance Organizations and the McCarran Ferguson Act", 7 *American Journal of Law & Medicine* 437, 438-439 (Winter, 1982).

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[2] ". . . [T]he most highly organized and committed model of an HMO employs physicians of various specialties and other health personnel or has them organized into a closed-panel group practice, and this model uses health facilities which are owned and operated by the HMO. Both the group practice and the HMO are devoted to serving the enrolled population groups full time, with minimal, if any, fee-for-service practice. This model is most closely identified with the Kaiser Foundation Health Plans. . . ." H. R. Rep. No. 451, 93d Cong., 1st Sess. at 10 (1973). See also S. Rep. No. 129, 93d Cong., lst Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3040.

The Internal Revenue Service will not grant charitable status to IPAs, and there is no basis for believing that they could obtain exemption as "charitable institutions" under the NIA. Moreover, many HMOs are for profit, and obviously are not covered by the NIA.

After more than 40 years of operation, and 10 years after the HMO Act, HMOs of the nonprofit group practice prepayment type, plus other HMOs that might be exempt as charities, serve less than four percent of the U.S. population. See *National HMO Census, 1983* (Interstudy 1983); *December 1983 Enrollment in the U.S., a Midyear Census* (Interstudy 1984).

The picture that the briefs supporting the petition would paint suggests that HMOs are about to monopolize the retail drug business. It is a portrait quite unrecognizable to a Program that after four decades has achieved a two percent market niche in the face of historical opposition from organized medicine and the continuing dominance of the monoliths of prepaid health care arrangements—Blue Cross/Blue Shield and commercial insurers.

REASONS FOR DENYING THE WRIT

1. The Rule for Deciding This Case Was Announced In *Abbott Laboratories*

Nonprofit institutions, as defined by the NIA, are specifically exempt from the Robinson-Patman Act so long as they stay within the bounds of their institutional functions. The first time that the Portland Retail Druggists Association came before this Court, in *Abbott Laboratories, supra*, 425 U.S. 1, there were some uncertainties regarding the NIA's scope. Was the NIA's protection limited only to those types of organizations that existed when the Act was passed? Was its protection limited only to those types of activities which nonprofit institutions

had historically engaged in? Could a nonprofit institution enter into profitable activities unrelated to its basic functions and still claim the protection of the NIA?

This Court accepted *Abbott Laboratories* to answer these questions, and it did. While the exemption is not "to be applied and expanded automatically to whatever new venture the nonprofit [organization] finds attractive in these changing days", it is also not "restricted and confined" to the "nonprofit [organization's] original or 'traditional' status." 425 U.S. at 13. As the Ninth Circuit correctly held, the test "inherent in the language of the statute" is whether the activity in question "is part of and promotes the [organization's] intended institutional operation." *Id.* at 14.

2. Prescription Drugs Dispensed To Members Of The Program Are Covered By The Nonprofit Institutions Act

a. The Health Plans Are Nonprofit and Charitable

Charity as a legal concept is synonomous with community benefit, and is not limited to almsgiving and relief of the poor. *Bob Jones University v. United States*, 461 U.S. 574, ____, 103 S. Ct. 2017, 2027-28, 76 L.Ed.2d 157, 171-72 (1983). "The ultimate test is undoubtedly benefit to the community." IV A. Scott, *Law of Trusts* § 369.2 at 2862 (3rd ed. 1967). "The common element of all charitable purposes is that they are designed to accomplish objects which are beneficial to the community." Restatement (Second) of Trusts § 368 at 247 (1959).

More than a century ago, this Court, applying what it termed "general principles of jurisprudence", said: "A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man." *Ould v. Washington Hospital for Foundlings*, 95 U.S. 303, 310, 311 (1877). Less than two years ago this Court

quoted these very words as it found that the "public benefit" definition of charity must have been intended by Congress when it enacted I.R.C. § 501(c)(3). *Bob Jones University, supra,* 574 U.S. at ____, 103 S.Ct. at 2027, 76 L.Ed.2d at 171. This Court also noted that, in applying the community benefit definition of charity, courts should look to "contemporary standards." *Bob Jones University, supra,* 574 U.S. at ____, 103 S.Ct. at 2029, n. 20, 76 L.Ed.2d at 174, n. 20.

That is, the "charity" concept is shaped by contemporary perceptions of social need, and the term must be interpreted in its cultural context as an evolutionary rather than fixed idea. Good health always has been an important social goal, and promotion of health therefore has consistently been regarded as a charitable purpose. Restatement (Second) of Trusts § 368 (1959). In this context, the HMO Act and its underlying policy to encourage plans such as the Program evidence a national consciousness that plans on the Program model serve an important contemporary community need and thereby confer an important community benefit.

The NIA explicitly exempts hospitals. Although there have been hospitals for centuries, comprehensive health care delivery systems such as the Program are of comparatively recent origin. The Program and plans like it represent a response to the increasing complexity of health care and the parallel need for increasingly sophisticated arrangements to assure that care is both timely and appropriate, and that it is provided at reasonable cost.

In the context of today's community needs, nonprofit group practice prepayment plans have a better claim to charitable exemption than hospitals. Although hospitals often are community health centers, their core function still is to provide inpatient care to acutely ill or injured patients. However, acute care represents a comparatively

limited element in the aggregate of services that comprise comprehensive health care. The Program, on the other hand, assumes responsibility not simply to provide episodic care, but to assemble and organize the totality of services that comprise comprehensive health care. This is the greater community need, and it is a need that group practice HMOs alone meet. The only reported cases considering the question hold that group practice prepayment plans are charitable. *Sound Health Association v. Commissioner,* 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2; *Harvard Com. Health Plan v. Board of Assessors,* 427 N.E.2d 1159 (Mass. 1981).[3]

Moreover, in an era in which runaway health care costs represent a national problem of crisis proportions, group practice HMOs consistently achieve financial savings for their members in the range of 10-40% as compared with traditional insurance or Blue Cross/Blue Shield plans serving similar population groups.[4] The Program emphasizes comprehensive outpatient care and early intervention, thereby reducing the need for costly hospitalization.

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[3] The *amicus* briefs revive a claim that was examined and rejected by both the District Court and the Court of Appeals. This claim is that the method of compensating the Medical Groups partially through a payment that is at risk and contingent upon Program financial results raises doubts about the Health Plans' non-profit status. After reviewing the Medical Groups' compensation arrangements, the Court of Appeals said (743 F.2d 1388, 1391, n. 4):

> "A small portion of the payment to the Medical Groups—generally around five percent of the total payment—does not depend solely upon the number of members in the Medical Group's region. This portion is withheld by the Health Plan and paid to the Medical Groups only if the Program organizations meet their yearly financial goals. This system of payment is designed to give the doctors in the Medical Groups an incentive to keep costs low, and it is required by regulations promulgated pursuant to the Health Maintenance Organizations Act. 42 C.F.R. § 110.104(b)(1)(v)."

[4] Manning, Willard G., et al., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services", 310 *The New England*

This characteristic enables the Program to compete effectively against traditional health care coverage.

The Health Plans have never claimed that they are charitable simply because they are qualified group practice HMOs under the HMO Act, nor do they claim that the HMO Act impliedly repeals any antitrust law. The Court of Appeals decision did not mention the concept of implied repeal.

The National Association of Retail Druggists suggests that judicial and administrative determinations that plans on the Program model are charitable for purposes of tax exemption is irrelevant in the antitrust context (NARD Brief at 9-11). However, the underlying policy of both exemptions is to free charitable institutions from constraints and impositions that otherwise would apply. The tax cases referred to and the Internal Revenue Service's determination that plans like the Program are tax exempt is founded on a determination of their charitable character under the general community benefit standard, and there is nothing in the NIA that suggests a different standard.

The National Association of Retail Druggists' statement that the organizations covered by the NIA do not compete with other purchasers (NARD Brief at 12) ignores the NIA's explicit exemption of nonprofit hospitals, which of course directly compete with proprietary (for-profit) hospitals, and the NIA's exemption of nonprofit schools, which compete with for-profit schools, particularly at the secondary level.

Journal of Medicine 1505 (June 7, 1984); H. Luft, *Health Maintenance Organizations: Dimensions of Performance* at 387 (John Wiley & Sons, Inc. 1981); H. Luft, "How Do Health Maintenance Organizations Achieve Their 'Savings'?", 298 *The New England Journal of Medicine* 1336, 1337 (July 15, 1978).

The test of charity is thus not absence of competition, it is whether the institution confers the requisite community benefit. At the same time, we again note that the Program does not compete in the plaintiffs' market, but is almost exclusively devoted to serving its members.

b. The Program's Drug Purchases Are For Its Own Use

In *Abbott Laboratories, supra,* 425 U.S. at 14, this Court said that in applying The NIA's "own use" standard to drug sales by hospitals:

> "... 'their own use' is what reasonably may be regarded as use *by the hospital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients."

The "own use" standard applicable to a hospital was analyzed by this Court in *Abbott Laboratories* in terms of user categories and their relation to the hospital's institutional function. Whereas hospitals have relationships with *patients,* the Program has relationships with *members,* who by the terms of their membership contracts are entitled to comprehensive benefits but must utilize Program facilities and services to obtain these benefits, including prescription drugs. In contrast to the historical hospital/patient relationship, which is limited to the duration of the inpatient stay, the Program and its members have a continuing relationship. The Program acquires and dispenses drugs to all members because it is essential to the Program concept of comprehensive care that appropriate drug therapy be integrated as part of members' health care. Thus, except for negligible non-member sales, all drugs acquired and dispensed through Program pharmacies are for the Program's "own use" in meeting its contractual obligations to members.

CONCLUSION

The legal issue raised by the petition is whether the Ninth Circuit correctly applied the *Abbott Laboratories* test. As such the petition raises no new or novel issues requiring Supreme Court guidance. Furthermore, the Ninth Circuit was right. The petition should be denied.

Respectfully submitted,

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